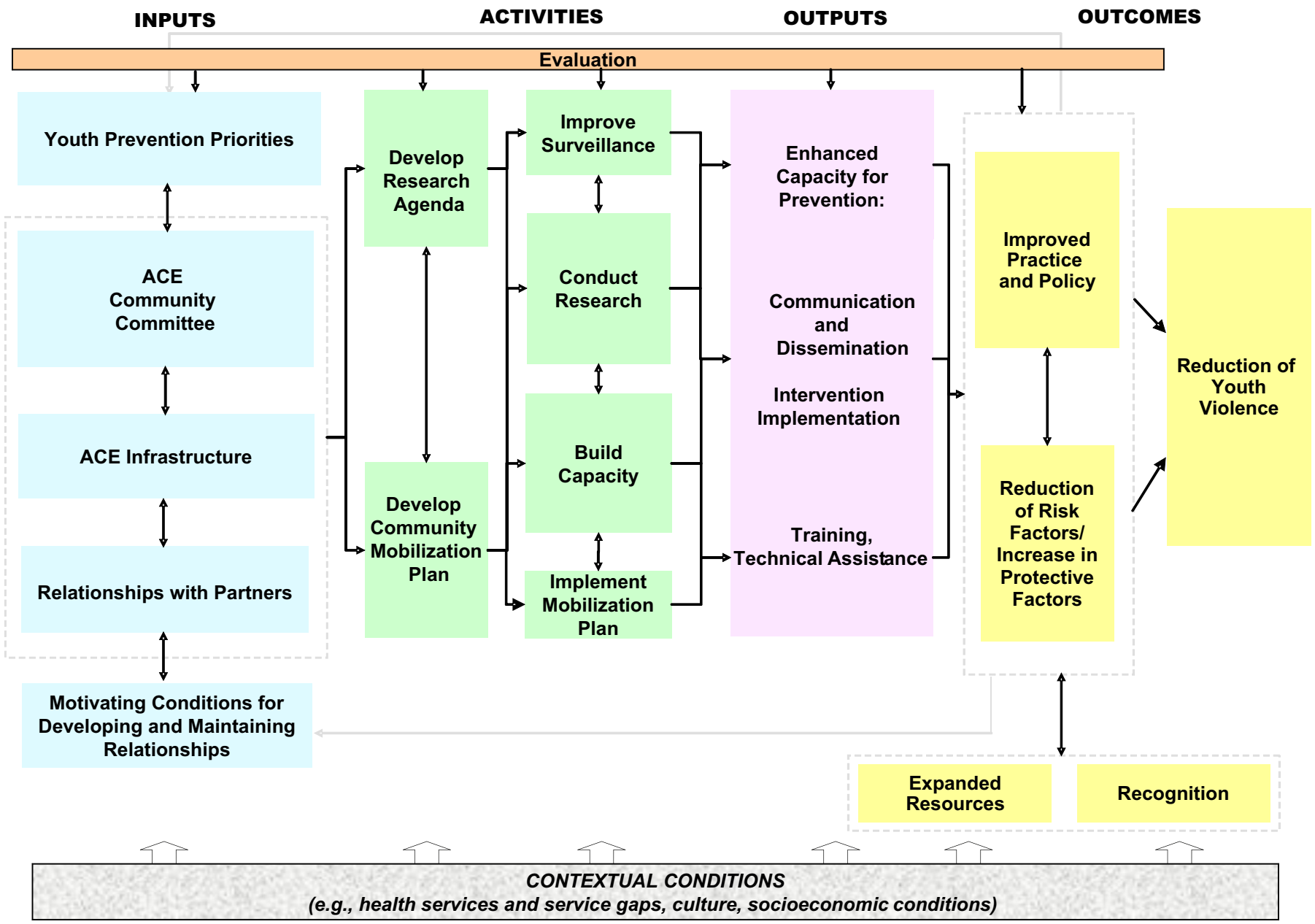
National Framework for the Academic Centers of Excellence Program



ACE Framework derived from logic model of the Prevention Research Centers

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Narrative Description of the Conceptual Framework

For the National Academic Centers of Excellence for Youth Violence Prevention (ACE) Program

The conceptual framework for the National Academic Centers of Excellence for Youth Violence Prevention (ACE) Program was developed to describe the future orientation of the program, its activities and the outcomes it expects to achieve. The national framework or logic model was created through a participatory process involving a diverse set of national, state, and local stakeholders and ACE grantees, and draws heavily from the Centers for Disease Control (CDC) Prevention Research Centers (PRC) model. The elements of the framework and its linkages are consistent with the Congressional language authorizing the establishment of the program, and CDC research policies.

This model serves as a planning mechanism for center in guiding their activities during the 5-year grant period. The framework identifies the inputs, activities, outputs, and outcomes common to all ACE's and shows the expected relationships among these components. The diagram of the framework summarizes how the program is presumed to work. Although the boxes of the framework are shown in a linear fashion, the relationships among them are expected to be complex, interactive, and recursive over time.

The national framework does not imply that one size fits all. To reflect uniqueness, each ACE should create their own logic model by tailoring the national framework or logic model to the center's specific activities and goals. The national framework cannot show the emphasis an individual ACE may place on one type of activity over another. The time required to achieve different outputs may vary among ACEs and depends on many factors, such as the type of research conducted and other activities undertaken, the amount of resources devoted to activities such as dissemination, and contextual factors. Thus, the framework does not specify the time it may take to achieve outputs or outcomes.

DIAGRAM NOTE: The size of the boxes in the diagram depends on the amount of text in each box and does not denote the relative importance of a specific element.

Inputs. The first column of the conceptual framework, inputs, refers to the assumptions underlying a program and the infrastructure that must be in place before a program can be implemented. The four inputs the framework captures are described below.

Youth Prevention Priorities. Each ACE is established to address youth interpersonal violence prevention priorities and enhance knowledge of effective youth violence prevention in a defined community. Community is defined as a group of people who share some or all of the following: geographic boundaries; a sense of membership; culture and language; common norms, interests, or values; and common health risks or conditions. [IOM 2002] [CDC/ATSDR Principles of Community Engagement] It refers to a population that has a distinct identity. It can mean residents of a geographic area, be that a catchement area, neighborhood, school district, city, county or region within a county. It can be used with a modifier or clause to describe a non-geographically based subgrouping such as, but not exclusively: a community of youth violence prevention workers, a community of health professionals, or an ethnic or language community. The ACE program focuses its research activities on the violence prevention issues of high priority to the defined community and that address state or national youth violence prevention priorities, and such gaps identified in the Research Agenda of CDC's National Center for Injury Prevention and Control and those stated in *Healthy People 2010*.

DIAGRAM NOTE: Two-way arrows connect the youth violence prevention priorities and
box and the next three combined input boxes.

ACE Community Committee. CDC will require each ACE to form or work with an existing ACE Community Committee. This group comprises members of the ACE's defined community and adult and youth representatives of agencies and organizations that serve the Center's designated community. The Community Committee participates in the Center's organization, research, or other activities. Committee members typically represent an identified group or population and participate in the committee in order to provide the perspective and knowledge of a designated population or group to the activities of the Center.

The inputs provided by an ACE Community Committee to the ACE include guidance, advice on ACE agendas and plans, expertise, contacts, essential information about the designated community as well as intangible benefits. Some ACE's may wish to form

additional advisory groups, as needed, such as a policy board, a youth advisory board, or advisory committees for individual research projects. The decision to form these additional groups depends on the needs of the ACE and the community.

ACE Infrastructure. Before conducting specific youth violence prevention research, projects, and health promotion activities, an ACE must have the necessary internal infrastructure. This infrastructure includes the necessary human resources capacity to recruit faculty with the necessary core expertise, diversity and sensitivity. It also includes the necessary evaluation expertise as well as faculty and staff who have the requisite multidisciplinary expertise to implement ACE projects and activities and experience working with the community, and expertise for evaluating the implementation of the ACE's activities and to assess the ACE's outcomes and accomplishments. The Centers are mandated to create an infrastructure that facilitates initiatives that involve researchers and practitioners from varied disciplines, and collaboration across university centers. Finally, ACE capacity requires communication and data systems that enable and facilitate work, and administrative capacity (e.g., financial resources).

Relationships with Center Partners. Each ACE is also expected to establish and maintain center partnerships with institutions such as state and local health, education, justice departments, other university partners, other ACEs, Injury Control Research Centers (ICRCs), Prevention Research Centers, national youth violence prevention organizations, and CDC. Partnerships are intended to strengthen the ACE's surveillance, research, training, mentoring, community mobilizing and dissemination activities in its identified community. Partners can collaborate with the ACE in designing and conducting research and other ACE projects and in disseminating research findings, which are expected to help facilitate the translation of public health research and related activities to practice and policy.

DIAGRAM NOTE: A dotted box around these three inputs indicates that the ACE, its community, and its external partners are the major stakeholders; they collaborate with each other to implement the ACE Program. The inputs for Community Committee, Infratructure, and Relationships with Partners also have two-way arrows touching each other. A two-way arrow connects the combined boxes for these inputs with that for the next input. One-way arrows also connect the three boxes to the first two program activities.

Motivating Conditions for Developing and Maintaining Relationships. The conceptual framework also recognizes the conditions motivating the development and maintenance of relationships with community partners and others. These conditions may include trust and tangible or intangible benefits (such as access to expertise or acceptance by a community) and sharing of resources gained from the partnership. These conditions may influence a partner's willingness to form a relationship with the ACE, the nature and strength of the relationship, and an ACE's ability to sustain the relationship over time.

Activities. The second and third columns of the conceptual framework capture the activities that include: developing a research agenda; developing a community mobilization plan; conducting surveillance, research, building capacity and implementing the community mobilization plan. (Multi-sectoral and multi-disciplinary collaboration and dissemination are inputs and outputs, respectively.)

Research Agenda. An ACE is encouraged to engage stakeholders within its defined community in developing an overall research plan, identifying research priorities, selecting research projects, recruiting research participants, refining research methods, developing interventions, conducting research, and reporting and disseminating research findings. ACE Centers are charged with establishing a five-year research agenda with tied to one or more HHS objectives, *Healthy People 2010, NCIPC Research Agenda, Guide to Community Prevention Services* and local youth violence prevention research priorities.

Community Mobilization Plan. ACEs are charged with the development and implementation of a five-year community mobilization or action plan (in collaboration with the Community Committee). Further, the development of a Community Mobilization Plan should be tied to the Research Agenda with an identified relationship to one or more youth violence prevention priorities.

DIAGRAM NOTE: A two-way arrow connects the boxes for the development of the research agenda and the development of the community mobilization plan. One-way arrows connect the boxes for the mobilization plan and the research agenda to the next set of activities. A two-way arrow connects the research agenda and the mobilization plan as these processes should inform one another.

Conduct Core Activities:

- *Surveillance.* This core area includes the gathering, analysis and interpretation of surveillance data to enable the defined community with whom the ACE is working to better measure the problem of youth violence, and accurately reflect trends in the target community and the greater community. All Surveillance activities proposed should include an appropriate translation and dissemination plan.
- *Research*. The research conducted should be informed by local priorities, the NCIPC Research Agenda, and contribute to new methods of study, understandings of, or ways to prevent youth interpersonal violence. In addition, ACEs may conduct research funded by other federal agencies and by state agencies, community-based organizations, and foundations. All research is expected to be conducted using sound research methods that further the field of youth interpersonal prevention research. All research proposed under the ACE program should include an appropriate dissemination plan.
- *Build Capacity.* ACEs are also charged with developing a five-year plan to train, provide technical assistance to, or mentor health professionals, researchers, practitioners, students, community members, and others. These activities, which are expected to be developed in collaboration with the recipients, may cover a range of topics, including youth violence prevention best practices, community building, research, and evaluation as well as other needs identified by ACE partners. ACEs may also train and provide technical assistance to community partners on implementing specific prevention and health promotion interventions, including effective practices.
- *Implement the Community Mobilization Plan.* ACE's are expected to form, nurture and advance partnerships with the community designed to implement evidence-based strategies or promising programs. Community implementation efforts can include convening stakeholders – including the most affected – helping to organize across different sectors, fostering strategic alliances, and strengthening community bonds; assessing community resources; mapping community assets; and enabling a fuller understanding of and response to the nature and dynamics of local violence.

DIAGRAM NOTE: Two-way arrows connect these four core activities to one another. One-way arrows connect surveillance, research, capacity building, and community implementation to the three

outputs (intervention implementation, communication and dissemination, and training and technical assistance).

Outputs. The fourth column captures outputs generated or produced as a result of program activities. Through the process of planning, carrying out public health-related youth violence prevention activities, and the promotion of collective action, it is expected that the professionals and community residents will gain increased skills and confidence (or a greater sense of "efficacy") enhancing its capacity for prevention. Enhanced capacity includes an improved ability on the part of agencies and organizations to implement and make well-reasoned decisions about effective violence prevention programs and services. It also includes enhanced academic infrastructure in service-learning, student practicum opportunities. This capacity combines a community's and a university's commitment, resources, and skills to respond to public health needs and priorities. Another aspect of enhanced capacity is the development of skilled "violence preventers." This term includes not only professionals – both developing new skills for those entering the field as young researchers/practitioners and improving existing skills of current violence prevention workers – but also providing skills to youth, parents, and volunteers. Community stakeholders who collaborate with the ACE's in implementing research projects and who participate in ACE-sponsored training and technical assistance improve their skills as a result.
The selected measurable products, or outputs, of these activities and processes are described below.

Communication and Dissemination. The communication and dissemination of research and evaluation findings are another type of output. These findings are typically published in peer-reviewed journals, books, and technical reports. They also may be presented to various audiences at professional conferences, community meetings, or other settings, and reported to the media. Findings from research conducted with a community should be shared with community partners and with other ACE's.

Intervention Implementation. Many ACEs develop, implement and test violence prevention strategies, programs and interventions in a community, encouraging the implementation of evidence-based strategies or promising programs. A program may rely on a curriculum, a manual, or a particular prevention strategy or health promotion tool, which is packaged and made available to interested organizations or individuals.

Training, Technical Assistance. ACE's training or technical assistance activities can include an assessment of the skills acquired, number of trainees and recipients of technical assistance, the number and duration of training or technical assistance events, and the satisfaction of participants with the training or technical assistance they received.

DIAGRAM NOTE: Together, all the output boxes connect to a combined set of two outcome boxes through a one-way arrow. These two outcomes connect to each other by two-way arrows.

Outcomes. The last column of the conceptual framework shows the outcomes, or the intended effects of cumulative program activities over time.

Improved Practice and Policy. One expected outcome of the ACE Centers' activities is the uptake of interventions and improved youth interpersonal violence prevention practice and policies. Surveillance, research, capacity building, and community implementation activities conducted by the ACEs are expected to be translated into community practice or policies adopted by local and state health departments, schools, other public agencies (e.g., recreation departments, housing authorities), and community-based organizations. Over time, these interventions and policies may be disseminated beyond an ACE's defined community and receive widespread use.

Reduction of Risk Factors / Increase in Protective Factors
Another expected outcome of the ACE Centers' activities is the reduction of risk factors/increase of protective factors in the community, a result of the uptake of improved violence prevention practice and policies.

Expanded Resources and Recognition. An ACE may be able to expand its resources beyond the core funding, research faculty, and initial organizational and agency partnerships that were formed when it first received CDC funding. An ACE may also gain recognition within a community and the nation for expertise in a particular field or area of youth interpersonal violence prevention, and for its partnerships.

DIAGRAM NOTE: One set of dotted lines surrounds the boxes for the two outcomes. A second set surrounds the two additional boxes below it (expanded resources and recognition). These groupings show the potential relationships with other components of the framework with which they are logically connected or which they are likely to influence or be influenced by. The outcomes flow

back through motivating conditions and up the input column. They also connect to youth violence prevention agendas and down the input column. A one-way feedback arrow also extends from the outcomes back to the inputs of youth violence prevention priorities and motivating conditions for developing and maintaining relationships.

Contextual Conditions. The box across the bottom of the conceptual framework is for contextual conditions, which are socioeconomic, political, and cultural factors external to the ACE Program that may not be within its control but which may influence the implementation of activities and achievement of outcomes. Note that these conditions may relate to all components of the framework.

Evaluation. Evaluation is a part of the ACE Program (noted at the top of the framework) that extends across all the inputs, activities, outputs, and outcomes, except for the ultimate outcome. The arrow to each column signifies that the ACE Program will evaluate aspects of each component, guided by performance monitoring and evaluation questions. Many factors can contribute to the final outcome, and empirical data demonstrating a causal link between proposed program activities and improvements in community health are lacking. Therefore, the ACE Program will not evaluate the ACEs' effect on violence-induced death, disability and injury among adolescents, but will evaluate program effect on improved practice and policy, and reduction of risk factors /increase in protective factors.

The Ace program evaluation will collect data that may include information about how inputs are being used to shape the ACE Program, which activities are undertaken by the collective program, the quality of the activities, and the specific outcomes the program is accomplishing. CDC, ACEs, and other stakeholders can use evaluation findings for many purposes, including modifying program activities or enhancing and strengthening relationships with community partners. Evaluation findings also provide information that can be shared with external stakeholders, can help document the program's value, and may provide justification for continuing or increasing program funding.